ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
P.O. Box 115512, Juneau AK 99811-5512

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

AWCB Case Number (Division Use Only):

EMPLOYEE: Answer ALL questions 1 - 20, sign, and give to your employer immediately.

1. Last Name First Name Initial	2. Telephone Number	3. Date of Birth	4. Sex ◯M ◯F	5. Social Security Number
6. Mailing Address	7. Residence Address			
6a. City State Zip Code	7a. City State Zip Code			
8. Place (City/Town/Village/Camp) Where Injury/Occupational Illness Happened	9. Date of Injury or Exposure to Disease		10. On Employer's Premises? ◯ YES ◯ NO	
11. Name & Address of Attending Physician	12. Hospitalization In-Patient? ◯YES ◯ NO	13. Name of Hospital		
City State Zip Code	City State Zip Code			
14. Describe Part(s) of Body Injured / Nature of Occupational Illness ☐ Left ☐ Right	15. Describe How the Injury or Occupational Illness Happened			

16. To all health care providers:
You are authorized to provide my employer (named in box 18), its workers' compensation liability insurance company (box 21), and its claims adjuster (box 22) information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 14. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature (box 17a). I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

Employee/Patient's Signature:

17. If Employee Unavailable for Signature, Explain Circumstances in this Space	17a. Date Signed

EMPLOYER: Review employee answers 18 - 20, answer questions 21 - 49.

18. Employer's Name	19. Employer's Alaska Address (If Different from Mailing)	
20. Employer's Mailing Address (Street and Number)	21. Name of Insurer	
20a. City State Zip Code / 20b. Telephone	22. Full Name and Address of Adjusting Company	
23. Date Employer First Knew of Injury / 24. Date/Time (AM / PM) Employee Left Work	22a. Mailing Address (Street and Number)	
25. Off Work After Injury / Illness? ◯YES ◯ NO ☐ 3 or More Days? / 26. Date Returned to Work / 27. Death? ◯Y ◯N Date	22b. City State Zip Code	22c. Telephone
28. Location Where Injury or Occupational Illness Happened	29. Employee's Occupation	30. Date Hired By Employer

31. Earnings Calculated By ◯Hr. ◯Day ◯Output ◯Wk. ◯Mo. ◯Yr.	32. Rate of Pay $ per	33. Days Employee Works per Week ◯3 or Less ◯4 ◯5 ◯6 ◯7	34. Describe Scheduled Days Off
35. Workday Began ◯ AM ◯ PM / 36. Employee Paid for Day Injured or Ill? ◯YES ◯NO	37. Federal EIN #	38. Give Details of How Injury or Illness Happened	

39. Injury / Illness Due to Machine / Product Failure? ◯YES ◯ NO	40. Mechanical Guard / Safeguards Provided? ◯YES ◯NO	41. List Any Machine / Substance / Object Causing Injury	42. If Machine, What Part?

43. Name and Address of Witnesses	44. If Injury / Illness Caused by Anyone Besides Employee, Give Name and Address
	45. Dependents (in case of death), Names and Addresses

46. If You Doubt Validity of Injury or Illness, State Reason

47. Signature of Authorized Employer or Representative	48. Title	49 Date Signed

WARNING TO EMPLOYEES AND EMPLOYERS: AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or employee misclassifications.

Distribution: Original -Workers' Compensation Division; Copy -Adjuster; Copy -Employer; Copy -Employee

Form 07-6101 (Rev 02/2010)

State of Alaska

Department of Natural Resources
Division of Forestry
Northern Regional Office

Sean Parnell, Governor

3700 Airport Way
Fairbanks, Alaska 99709-4699
Phone: (907) 451-2660
Fax: (907) 451-2690

Date: _____

To Health Care Provider

The following individual is a State of Alaska employee on an incident assignment. This letter is your authorization to provide treatment for any potential worker's compensation injuries or illnesses.

Name: _____

Social Security Number: _____

Please provide the necessary care to this employee and submit invoices/bills to:

Harbor Adjustment Services
1900 West Benson Blvd. Suite 101
Anchorage, AK 99517
Phone: (907) 277-1377
Toll Free: 1-800-478-1377
Fax: (907) 277-4143

If you have any questions regarding State of Alaska employees, call:
Northern Region Administrative Assistance at 907-451-2662
Coastal Region Administrative Assistance at 907-761-6205

Your assistance is greatly appreciated.

Sincerely,

John "Chris" Maisch
State Forester

STATE OF ALASKA

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Name of Injured/Damaged Equipment/Property _____

Job or Activity at Time of Accident _____ Date of Accident _____

Exact Location _____ Time _____

1. **WHAT HAPPENED?** _____

Tell what the employee was doing, how the accident occurred, and what thing directly injured the employee.

2. **WHY DID IT HAPPEN?** _____

Get all the facts by studying the job and situation involved. Use the following factors to help you identify the condition responsible.

OPERATION FACTORS TO BE CONSIDERED:

Proper Equipment	***Proper Material***	***People***
Selection	Selection	Selection
Arrangement	Placement	Placement
Use	Handling	Training
Maintenance	Use	Supervision

3. **WHAT SHOULD BE DONE?** _____

What action(s) will prevent similar accidents in the future?

4. **WHAT HAVE YOU DONE THUS FAR?** _____

Take or recommend action, depending on your authority.

5. **HOW WILL THIS IMPROVE OPERATIONS?** _____

How will it help us meet our objective – ACCIDENT PREVENTION?

6. **WHAT IS YOUR ESTIMATED COST OF THIS ACCIDENT?**

Cost of lost wage and medical expenses? ..... _____

Damage to State property or equipment? ..... _____

Damage to third parties, property and people? ..... _____

TOTAL _____

Investigated By _____ Date _____

Unit/Division/Department _____

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